the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE

WINTER, 1958-1959

DOROTHEA LYNDE DIX

THE WALLACE HOSPITAL
4246 Southern Avenue
Memphis, Tennessee

the psychiatric bulletin

for the physician in general practice

Editorial Office The University of Texas
6723 Bertner Drive
Houston, Texas

Business Office The Medical Arts Publishing Foundation
1603 Oakdale Street
Houston, Texas

The Cover

- In 1841, Dorothea Lynde Dix (1802-1887) began her vigorous efforts to alter the squalid surroundings of mentally ill patients. During the next five years, she inspected 18 state penitentiaries, 300 jails, and 500 almshouses. At that time there were 13 hospitals in the United States to provide care for the mentally ill. About her hospital inspections, Isaac Ray said that the consequence when anything was found amiss was "worse than an earthquake." When Miss Dix retired 40 years later, she had personally founded 32 hospitals, and 78 more had been established as a direct result of her influence. Her work was extended to Europe, where she achieved major reforms in Scotland and in the Vatican. In addition to founding hospitals, Dorothea Dix helped to effect legislative changes in America and abroad. During the Civil War, she was appointed the first Superintendent of Army Nurses.
- The cover portrait was drawn by Joseph F. Schwarting.

The Psychiatric Bulletin is owned and published quarterly by The Medical Arts Publishing Foundation, The University of Texas, 6723 Bertner Drive, Houston, Texas. Publication dates: 1st day of December, March, June, and September. Subscription rates: $3.00 per year. Single copy 75 cents. Address all Business Correspondence to The Psychiatric Bulletin, 1603 Oakdale Street, Houston, Texas.

the psychiatric bulletin

Volume IX • Number 1 • Winter, 1958–1959

CONTENTS

The Terminal Patient

● Certain attitudes toward death are basic to the workings of the human mind while others are influenced by the individual's education, experiences, and religious beliefs. The common factor is an ever-present awareness of personal existence, although there is no particular reaction to imminent death that is common to all persons. Physicians are taught the specific medical procedures to be employed in the care of dying patients, but much less is learned about management of the patients' emotional reactions at this time. Even less is explained about the reactions that the physician may himself experience toward a dying patient. This last, the understanding and control of his own attitudes, is second in importance only to recognition of the patient's needs.

The patient

The wish to live is strong in almost every individual, and, inherent in normal reluctance to die is, of course, the apprehension felt toward an unknown experience which must be undertaken alone. Many persons, however, are able to accept the thought of death with some degree of tranquillity. Others become emotionally disorganized and suffer intense anxiety. Prolonged painful illness contributes to feelings of isolation.

Eissler has remarked the differences in patient-attitudes toward serious disease. Generally, instead of response in terms of objective properties of the illness, each patient creates subjective imagery in accordance with the unconscious meaning which the disease and the affected organ have for him. Although such attitudes are entirely individual, similar reactions to particular diseases have been observed. For example,

cancer seemingly connotes progressive and relentless devouring of the patient. In contrast, cardiac disease apparently produces imagery of a less merciless course. It has been noted that even when the type of cancer involvement and the type of cardiac disease have equally poor prognoses, the same imagery persists.

A frequent reaction to knowledge of imminent death is that of overwhelming fear. Eissler has differentiated the fear of death from the fear of annihilation. He says that ". . . the fear of annihilation pertains primarily to the fear of the body's destruction but does not necessarily include the destruction of the psyche, soul, ego, or personality, or whatever still must be added in order to convert fear of annihilation into fear of death." The fear of annihilation begins in infancy and, presumably, is continued as a universal phenomenon. The fear of death, as the phrase is used in this author's context, is not considered universal. Eissler points out, however, that one type of fear may easily evolve into the other, and it is often difficult to distinguish clinically between the two.

Sheps has described a theory of the underlying emotional factors in pathogenic fear of death. Psychoanalytic studies have shown that patients with such fear consider themselves to be inadequate and unlovable. This distorted self-image is deeply repressed, and usually results from early experiences in which the person did not receive enough assurance that he was effective, adequate, and lovable. An individual who is fundamentally sure of his own competency and reasonably tolerant of his own imperfections, will usually have accomplished a successful enough record of achievement to prepare him to meet new situations without great anxiety. Sometimes an individual whose image of himself is inadequate manages to function successfully because other persons supply necessary reassurance; however, the prospect of an experience which must, finally, be a solitary one results in the same overwhelming fear.

Intense fear of death may be manifested in other ways than by verbal admission. For example, it may be denied, displaced, or suppressed. The patient who disputes the imminence of his own death does so because he finds the idea untenable. The mechanism of denial is evidenced by obvious avoidance of discussion. The patient may deny his illness, or he may simply avoid asking questions about prognosis. Displacement may be effected by preoccupation with some minor disorder which is unrelated to the serious illness. The patient who suppresses fear of death is usually a more mature individual who has been able to manage unpleasant circumstances realistically. Such a patient may control his reaction to impending death by construction of a facade to conceal his own personal emotion.

All terminal patients require particularly close observation. One of the principal rules in care of the patient is that his particular defense mechanism should be respected unless the advantages of altering it outweigh those of supporting it. The physician who supports whatever attitude the patient finds most comforting may prevent a grief reaction, which, added to physical debility, may hasten death, either by suicide or by loss of the will to live.

If, however, the defenses of avoidance and denial become inadequate, and the patient's fear becomes uncontrollable, a more active kind of support is necessary. The patient will need reassurance of his personal worth and lovability. Usually, this is best accomplished when the physician can adopt the part of parent-substitute and give the patient a feeling of being cared-for, protected, and secure. This type of relationship is ideal at the actual time of death.

The physician

The most difficult professional situation which a physician must experience is the death of a patient. Worcester remarked that despite the extensive progress in most medical practices during the past half-century, the medical approach to care of the dying has deteriorated. In fact, according to this investigator and others, there has been a greatly increased tendency to delegate the care of dying patients to nurses and relatives. Because less professional interest is taken in such service, less is known and taught about it.

The physician who decreases his visits to a dying patient probably does so for a number of reasons. First, there is an element of inherent helplessness. A physician is expected to cure patients of illness and to preserve life. When he is unable to do so, the admission of failure is onerous. Second, the mechanism of identification may result in feelings of depression and anxiety. He may fear that these reactions will be communicated to the patient. Third, deep feelings of compassion, sympathy, and other emotional involvement may be disquieting to him. Finally, over-concern about the patient may cause the opposite of avoidance which results in almost obsessive care and zealous continuation of treatments which are no longer indicated.

Hollender recommends that a physician overcome any tendency to avoid care of dying patients by concentration upon the incidental complaints that he can ameliorate. Although the actual care may not alter the outcome, the psychological benefit to the patient will be immeasurable. In addition, the family will be relieved of the burden of decisions, and will be sustained by the knowledge that everything possible has been done for the patient.

Conclusion

Despite the fact that the meaning of death is different for each individual, there is one feature which probably is common to every person. This is the hope that he will be able to accept death with dignity. In order to do this, he may need the spiritual help of his pastor to confirm and strengthen his religious beliefs, the supportive care of his physician to maintain optimal physical and emotional comfort, and the reassuring presence of family members.

Suggested Reading

Aldrich, C. K.: Psychiatry for the Family Physician, New York, McGraw-Hill Book Company, Inc., 1955, p. 10.

Eissler, K. R.: The Psychiatrist and the Dying Patient, New York, International Universities Press, Inc., 1955, p. 243.

Hollender, M. H.: The Psychology of Medical Practice, Philadelphia, W. B. Saunders Company, 1958, p. 112.

Ogilvie, H.: Journey's End, Practitioner **179**:584 (Nov.) 1957.

Sheps, J.: Management of Fear of Death in Chronic Disease, J. Am. Geriatrics Soc. **5**:793 (Sept.) 1957.

Worcester, A.: The Care of the Aged, the Dying and the Dead, 2nd ed., Springfield, Ill., Charles C Thomas, 1950, p. 33.

Schools of Psychotherapy

PSYCHIATRIC THERAPY may be defined as any process or procedure which alters behavior, influences toward better adjustment to environment, or promotes peace of mind. By this definition, Nolan D. C. Lewis has described, in broadest terms, the ultimate objectives of psychiatric care. The methods by which these aims are achieved are usually referred to as systems or techniques. In the past, different approaches were demarcated in accordance with the orientation of particular groups of psychiatrists. The major orientations or schools of psychotherapy were established by Freud, Jung, Adler, and Meyer. Their methods were, correspondingly, psychoanalysis, analytic psychology, individual psychology, and psychobiology. Freud's approach is generally accepted as the classic one, and the other approaches each represent the originator's differences in opinion about certain aspects of Freud's teachings.

Psychoanalysis (Freud)

Among the several basic concepts in modern psychoanalytic approach is the theory of libidinal organization of personality formation. The term *libido* is defined as the psychic drive or vital energy associated with all instincts. The different stages of psychosexual development include the oral phase, during the first year of life; the anal phase, second and third years; and the genital phase, fourth or fifth year to adolescence. Specific characteristics are believed to develop during these stages, and particular attention is given to the individual's management of the Oedipal situation. A second concept concerns significance of the unconscious from which repressed material continues to exert influence and affect behavior. The personal structure is made up of the id, or reservoir of instinctual impulses; the ego, or integrating part which coordinates id tendencies with external reality; and the superego, or conscience, which incorporates the code of society. This structure is not considered to be rigidly compartmented, nor is psychosexual development divided into exact periods. Both theories are intended only to form a framework for evaluation and treatment of the patient.

Therapeutic procedures are derived from the following concepts. First, it is believed that psychic phenomena have definite cause-and-effect relationships. For example, such manifestations as lapses of memory, slips of tongue, dreams, and fantasies are not accidental happenings. Instead, they occur as the result of psychic determinism, and are, therefore, significant in analysis. Second, the patient protects himself from the distress of painful memories by defense mechanisms and is reluctant to forego these measures. This reaction is termed *resistance*. The technique of free association was devised to circumvent resistance in order to elucidate areas of conflict. Third, transference is considered requisite to successful psychoanalysis. In order to help the patient achieve emotional re-education, he must experience again the early conflicts which were not resolved. During analysis, the patient returns to the dependent attitudes of infancy and childhood. There are two particular reasons for the success of this method. One is that the emotional involvement in analysis is less intense than in the original situation. The other is that the analyst maintains an objective, stable, and understanding response in contrast to the attitudes of a parent or parent substitute. By this means, the patient is made aware, both intellectually and emotionally, that the reactions he had as a child are irrational for an adult, and is then helped to adopt new patterns of response.

SIGMUND FREUD

Analytical psychology (Jung)

The school of analytical psychology differs from the classic psychoanalytic approach both in semantic interpretations of terms and in some basic concepts. For example, the influence of libidinal factors in emotional disturbance is minimized. Instead, the theory of a *collective unconscious* is emphasized. Each progression in the development of man is believed to have formed an imprint upon the unconscious of all individuals. Similarities in folklore and legends throughout the world are sometimes cited as examples of this concept. The barrier between the individual and the collective unconscious is impenetrable, but a core of personality, called the *anima*, is believed to have contact with this source of libido or vital energy. The term *ego* connotes that part of mental function which mediates between the self and the contents of the conscious. The aspect of mental function which deals with reality is called the *persona*. In addition to these concepts, the popular terms *extravert* and *introvert* derived

from this school of psychologists.

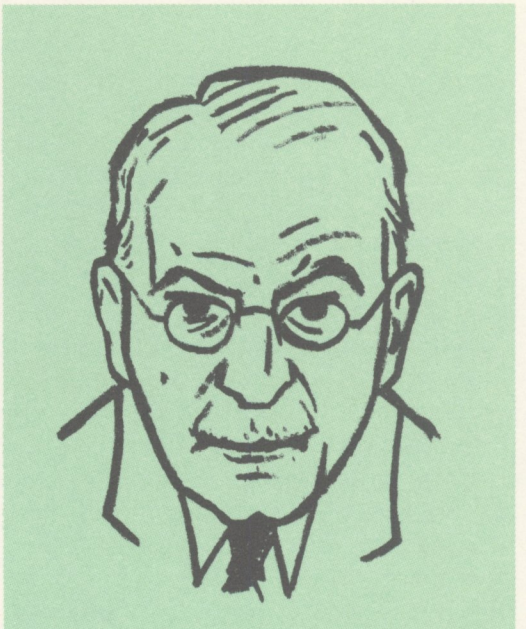
Mental disorder is perceived as a disturbance of one of four primary psychologic functions. These are direct, logical thought, feeling (value appreciation), sensation, and intuition, which is influenced by contact with the collective unconscious. Emotional disorders result when one of these functions becomes overactive, requires excessive libido, and thereby deprives the other functions of vital energy. The depleted functions then retreat into the unconscious where they are reinforced with libido and cause disruptive tension.

The theory of analytical psychology has not been accepted as extensively in this country as it is in Europe. Until about 1935 the therapeutic techniques included use of free association and dream interpretation, as in psychoanalysis. The therapist's conclusions would, however, be different. For example, a dream about cannibalism might be interpreted by a psychoanalyst as symbolic of aggression or eroticism. An analytic psychologist, in contrast, might interpret it as a regression to primitive belief that ingestion of life provides mystic power. Since 1935, when psychoanalysis became less popular in Europe, analytic psychologists have employed techniques that were individually modified.

Individual psychology (Adler)

Proponents of individual psychology deny the significance of psychosexual developmental stages, and consider that repression and unconscious stimuli merely provide emotional tone to insure acceptance by others of ideas and actions. The term *masculine drive* is substituted for libido. The concept of masculine drive was derived from a combination of Schopenhauer's philosophy of the will-to-live and Nietzsche's will-to-power. In women, this drive is called *masculine protest*. The masculine drive or protest is particularly apparent when evoked as overcompensation for feelings of inferiority, or *inferiority complex*. Reactions against such feelings may be so consistent that they form a characteristic pattern called *life style*. Dreams and fantasies are believed to represent trial solutions to problems, as well as preparation for realistic action. When motivations are not realistic, they produce neuroses. In this orientation, the aspects that are cited by psychoanalysts as secondary gains are considered to be primary objectives. For example, the purposes of neurotic symptoms are listed as escape from responsibility, protection against failure, postponement of decision, retreat to a dependency state, and covert control of environment. Sexuality is not considered to have the pervasive influence attributed to it by psychoanalysts. The neuroses in which sexual disturbance is a factor are described as overcompensation, as in avoidance or Don Juanism in men, frigidity or prostitution in women.

The therapeutic approach employed differs considerably from that of psychoanalysis. Free association, dream analysis, and release of conflicts in transference relationships are considered unnecessary, misleading, or even possibly harmful. Instead, the patient is given direct explanation of the nature and purpose of his neurotic life style, the detrimental effect elucidated, and the patient then encouraged toward a more realistic and successful adjustment.



CARL JUNG

Psychobiology (Meyer)

The differences in theory between psychoanalytic concepts and those of psychobiology are not pronounced. In the psychobiologic school, the *longitudinal* study of the patient is emphasized, and includes investigation of all psychologic, biologic, and sociologic factors which may have contributed to the origin of illness. During therapy, such methods as free association, dream analysis, and symbolic interpretation are utilized. Other similarities to psychoanalysis include diagnostic evaluation that is related to the patient's underlying motivation, and a carefully formulated plan of therapy in which any indicated technique may be utilized. The goal is also the same—that of a synthesis of the patient's total personality. Probably the greatest difference between the psychobiologic and the psychoanalytic schools is that the former is considered nonanalytic. Although many of the same techniques are employed, less effort is made toward investigation of the unconscious or the deeper layers of personality. Further, both therapist and patient assume active parts in the therapeutic process, and the responsibility for achievement is shared. At the conclusion of each interview, the therapist usually summarizes the gains so that the patient may consolidate them gradually.

Interpersonal relationships (Sullivan)

In this school, the importance of interpersonal relationships and the significance of cultural and social factors in mental illness are emphasized. Fromm-Reichmann defined psychiatry and psychoanalysis in this orientation as "the sciences and art of interpersonal relationships." It is believed that mental disorders result from and are perpetuated by inadequate communication, with anxiety as the inhibiting factor. Therapeutic techniques include listening, with subsequent explanations in nonpsychiatric terms. In general, the therapist's attitude is warm, accepting, and active. An aloof professional manner is believed to be indicative of the therapist's anxiety and is to be avoided. Sexual material is not emphasized because this practice may result in the patient's covering or escaping from more deeply conflictual aggressive or dependent attitudes. Resistances are not attacked directly because they are part of the patient's security maneuvers and direct attack may only strengthen them. One technique is that of split transference. For example, in care of hospitalized

patients, one psychiatrist assumes a nonauthoritarian role, while another adopts a position of authority in order to provide direction. Another aspect is the particular attention given to the patient's family and friends. The persons who are interested in the patient's welfare are always interviewed at the beginning of treatment and near the end, and sometimes during the course of treatment. The importance of such a practice is illustrated by Diethelm's recent comment. He noted that relatives often experience anxiety and bewilderment because of unexpected and misunderstood changes in the patient's behavior. Obviously, their anxiety may, in turn, affect the patient's progress. This circumstance is less likely to occur with hospitalized patients, but is common in private practice unless the therapist deliberately includes communication with relatives as a part of the treatment.

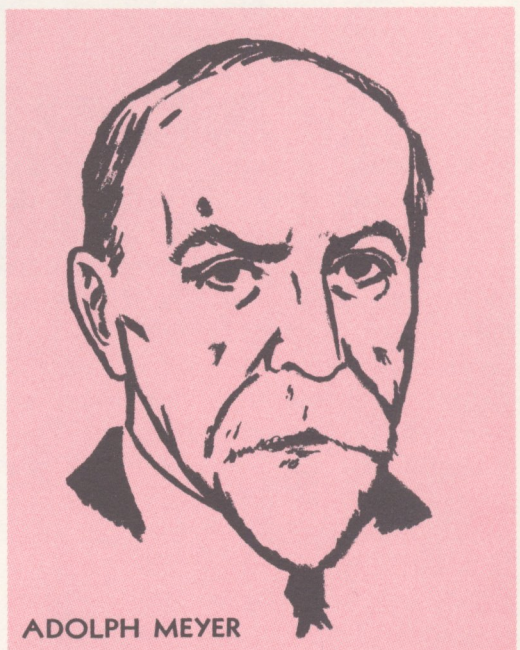
Other techniques

There are several other types of approach which are characterized primarily by procedure instead of the therapist's particular orientation. The *nondirective* or "client-centered" psychotherapy (Rogers) is one that is suitable for relatively stable persons who have minor personality maladjustments. In nondirective psychotherapy, the patient assumes the responsibility for direction and fruition of treatment. The therapist provides a friendly and permissive atmosphere so that the patient may express his feelings without fear of censure or retaliation. The patient's attitudes are not interpreted to him but may be clarified by a process called *reflection*, which is a repetition of what the patient has said, sometimes in different words. The therapeutic process consists of five parts. First, the patient applies for help of his own accord. Second, he expresses his emotions freely, particularly hostile and aggressive ones. Third, as he discusses his problems with a permissive listener, he develops insight and improved perspective. Fourth, the patient then becomes interested in positive courses of action. The therapist does not lead or direct at this time, but will help to clarify the values of different courses of action. The fifth part is the termination of the therapeutic relationship. This decision is made by the patient when he has gained enough self-confidence so that he no longer needs help.

ALFRED ADLER

Other techniques include *long-term* and *goal-limited* therapies which are differentiated by objective. In long-term therapy, the patient's entire personality is reconstructed. This process usually requires several years of treatment. In goal-limited therapy, the objective is the resolution of specific conflicts or problems in order to help the patient toward more immediate adjustment. This usually requires a shorter period of treatment, but it may also necessitate a psychoanalytic approach to the particular problem. *Surface therapy* is employed if the patient's defense mechanisms are considered to be the best solution to his conflicts. In this case, the existing defenses are reinforced in order to provide optimal adjustment. This form of treatment is also called *supportive therapy*. In *depth therapy*, suppressed conflictual material is uncovered and resolved, and this method probably provides more lasting personality adjustment. *Segregated therapy* is differentiated from *milieu therapy* because, in the former, attention is directed toward resolution of emotional conflicts without specifically relating therapy to other aspects of the patient's adaptation. In milieu therapy, (also called "total push"), every aspect of the patient's activity is included in the therapeutic plan. This procedure is used most frequently in hospitals, where the plan for treatment can be explained to all persons who have contact with the patient.

In recent years, there has been an increased tendency toward consolidation of the different schools of thought. Although some psychiatrists still adhere to a particular orientation, many others select from each the concepts which seem most valuable. There is also, presently, a greater tendency to employ whatever technique seems most suitable for the individual patient. Freud said, "There are many ways and means of psychotherapy. All methods are good which produce the aim of therapy."



ADOLPH MEYER

Suggested Reading

Alexander, F.: Fundamentals of Psychoanalysis, New York, W. W. Norton & Company, Inc., 1948, p. 33.

Arieti, S.: Interpretation of Schizophrenia, New York, Robert Brunner, 1955, p. 19.

Bowman, K. M., and Rose, M.: Do Our Medical Colleagues Know What to Expect from Psychotherapy?, Am. J. Psychiat. **111**:-401 (Dec.) 1954.

Cameron, D. E.: Activity of Therapist in Integrative Forms of Nondirective Psychotherapy, Am. J. Psychiat. **109**:183 (Sept.) 1952.

Coleman, J. C.: Abnormal Psychology and Modern Life, 2nd ed., Chicago, Scott, Foresman and Company, 1956, p. 566.

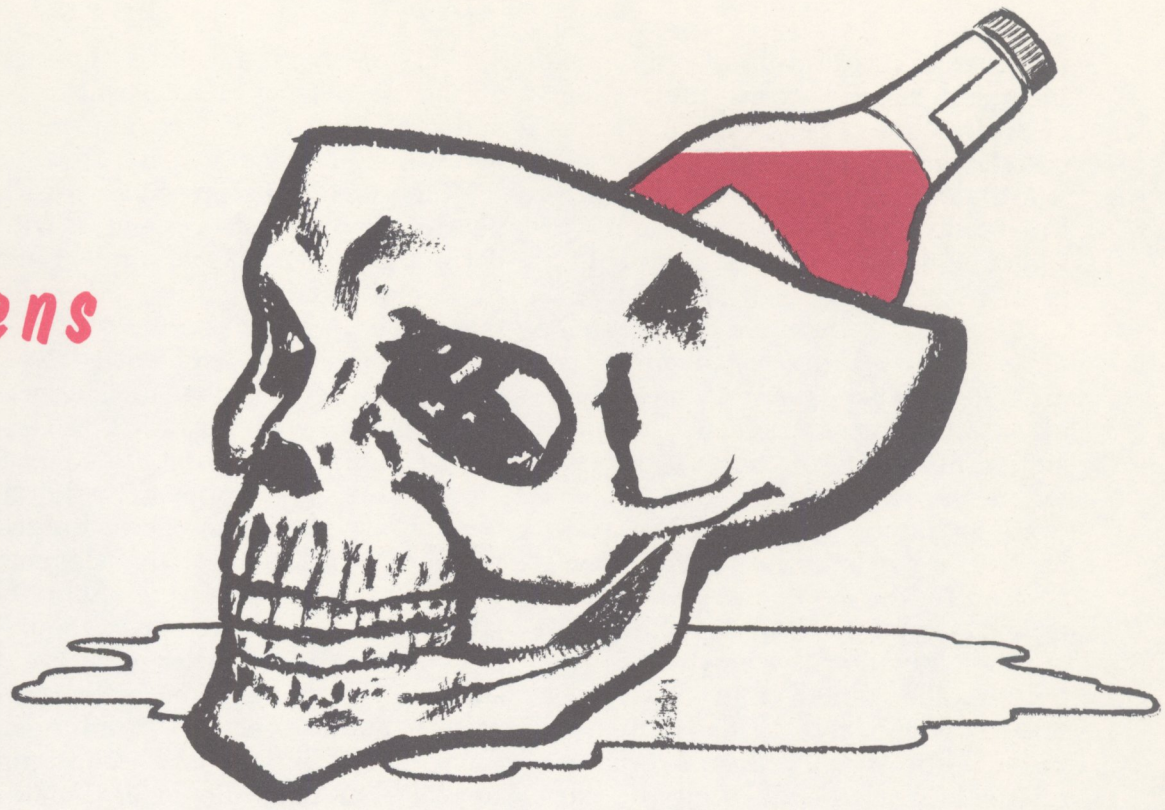
Diethelm, O.: Some Guiding Concepts in Psychotherapy, Am. J. Psychiat. **114**:805 (March) 1958.

Fromm-Reichmann, F.: Psychotherapy of Schizophrenia, Am. J. Psychiat. **111**:410 (Dec.) 1954.

Lewis, N. D. C.: Historical Roots of Psychotherapy, Am. J. Psychiat. **114**:795 (March) 1958.

Masserman, J. H.: The Practice of Dynamic Psychiatry, Philadelphia, W. B. Saunders Company, 1955, p. 406.

Delirium Tremens



● Delirium tremens is probably the most common form of exogenous toxic psychosis, and its symptoms represent a classic example of this category of disorder. Although the immediate cause of illness is impairment of brain tissue function, the process is usually reversible, and most patients recover with adequate care.

Delirium tremens occurs in approximately four per cent of persons who are addicted to alcohol. Contrary to popular belief, the disorder is not necessarily precipitated by sudden abstinence from drinking. It may occur during an alcoholic debauch, or shortly thereafter, or during abstinence. Concurrent causes in the predisposed alcoholic include malnutrition, vitamin deficiency, trauma, and infection. The pathologic process has been identified as generalized brain edema, accumulation of fluid in the interstitial spaces, and edema of the neurons. The severity of symptoms is usually directly related to the degree of brain impairment. Sometimes, however, there may be concomitant psychologic disorders which, although not related to the severity of brain involvement, are released by organic dysfunction and are superimposed upon it.

The physical signs and symptoms of delirium tremens include pronounced tremor of the hands, tongue, and lips, excessive perspiration, weak, rapid pulse, hypotension, albuminuria, coated tongue, and malodorous breath. Mental disturbance results from disorder in the level of consciousness, and is evidenced by disorientation, hallucination, sensory deception, intense fear, and extreme suggestibility. An additional diagnostic feature which is related to all toxic deliria is the varied intensity of mental symptoms during the course of illness. The patient may appear to have recovered, only to return to a severely psychotic state. Characteristically, exacerbations occur at night, while improvements occur during the day. Although both diagnosis and treatment of such patients are medical problems, consideration of the psychiatric aspects provides greater understanding of the patient's affective changes and promotes optimal care.

The onset of delirium tremens is usually preceded by a period of restlessness, insomnia, and feelings of apprehension. As the disorder progresses to a state of delirium, consciousness becomes clouded, attention is shallow and transitory, and memory, particularly for recent events, becomes defective. Because critical awareness is lacking, suppressed emotions are given free expression. For example, a part of an object may be interpreted as a complete experience, related to individual drives and fears. This phenomenon was demonstrated by a patient who mistook a white napkin for a ghost that had been sent to punish him.

The hallucinations are usually of such small, fast-moving animals as rats, snakes, and roaches. To the patient, great hordes of these may seem to attack him from all sides. Occasionally, larger animals are imagined, some of which are perceived as a particular species, while others are combinations of horrible shapes. Such hallucinations are so real to the patient that he not only fears for his own safety but may also warn others. Any attempt to question the validity of these observations will only strengthen his conviction that he is misunderstood and that, therefore, everyone is in danger. Unlike the schizophrenic, the patient with delirium tremens does not believe that the dangers are only toward him. Sensory disturbances include sensations of burning or tingling, or of insects crawling over the skin. Sensitivity to light may be demonstrated, although hypersensitivity to sounds is more common. In most cases, all that the patient hears, sees, and imagines is interpreted by him as threatening to his person.

Disorientation as to time, place, and person may be extreme. Even when the patient asks and is told the date or the place, the information is immediately forgotten. Because of memory impairment and clouded consciousness, the patient is unable to relate to the environment. He may not recognize well-known objects or persons, nor identify his place in his surroundings. For example, a patient who was confined to bed in a hospital room insisted that he was at work in a factory. Past experiences, either personal or otherwise, real or fantasied, merge into confused and conflicting imagery.

Fetterman has described the psychodynamics of delirium as compared with those of rational thought. The

processes of lucid thinking and sound judgment depend upon integration of all functions. Sensory stimuli are correlated with past experience; time is evaluated correctly and events are fitted into logical sequence; fantasy is distinguished from fact; and identification of self in relation to others is intact. With impaired brain function, however, this organization is disrupted. The patient is incapable of interpreting extraneous stimuli, and, simultaneously, he is subjected to pressure from emotions which were previously suppressed because he can no longer control them. Fear is usually the predominant uncontrolled emotion. If the impairment of brain function is sudden and extensive, the patient may lose consciousness entirely. In delirium tremens, however, the process is usually relatively gradual, and thus the patient has time to misinterpret stimuli and to be overwhelmed by fear, sometimes even to the point of suicidal attempts. In some cases, suicidal attempts are actually escape attempts. Fenichel has pointed out that when alcoholic addiction is employed as a means to avoid depressive breakdown, it is not surprising that a "break with reality" occurs if the preventive measure becomes inadequate.

The medical treatment of patients with delirium tremens consists of withdrawal of alcohol, and administration of fluids, salt, glucose, vitamin C, and the complete vitamin B complex. High caloric intake should be maintained, either by mouth or parenterally. Previous methods of sedation included a continuous warm tub, and use of paraldehyde or chloral hydrate. After the introduction of tranquilizing drugs, however, the phenothiazine derivatives were generally accepted as preferable agents for chemical sedation. Recently, successful results were reported after administration of promazine hydrochloride in initial doses of 200 mg. to 300 mg. with maintenance doses of 50 mg. to 100 mg. The barbiturates and bromides are not recommended because of their cumulative effect.

The psychiatric principles which pertain to care of a patient with delirium tremens were summarized by Romano and Engel in a reminder that, "All delirious patients who are not stuporous are frightened." Specific measures include suicide precautions, protection against self-injury, constant reassuring attendance, and minimal extraneous stimuli. Nursing procedures should be limited to those consistent with adequate physical care. It is also advisable to have lights kept on whenever the patient is awake, in order to prevent shadows which might be interpreted as threatening objects. Consultation, discussion of illness, and interpretation of symptoms should be avoided in the patient's presence.

Delirium tremens may last from three to six days. If the patient has not recovered at the end of two weeks, the diagnosis of Korsakoff's syndrome must be considered. Death during delirium tremens usually results from cardiac failure, bronchopneumonia, or direct brain involvement, and the rate has been cited as high as from ten to 15 per cent of cases. During the past three years, both the duration of illness and the mortality rate have been reported as greatly reduced by use of phenothiazine derivatives.

Although most patients do recover from delirium tremens, individual recurrences are common. An attitude of apology and determination to avoid another episode is characteristic of the period immediately after recovery. This after-effect is seldom lasting, however, and the fundamental problem of alcoholic addiction is not resolved. Of particular interest, however, are those patients who do undergo an apparently spontaneous cure of alcoholism after an episode of delirium tremens. Alexander states that, in such cases, the delirious state is comparable to the mental confusion which results from electric shock therapy. The fact that relatively few alcoholics profit from the experience of delirium tremens is attributed to another factor. In studies of patients who stopped drinking after delirium, it was found that in the terminal stages of delirium the dreadful hallucinations changed to extremely pleasant visions, usually of a religious nature. In each instance of this type, the patient had previously been prepared for the happening, usually by a reformed alcoholic who had had a similar experience. It is interesting to note that one of the cofounders of Alcoholics Anonymous attributed his own recovery to such an experience, which also occurred after his contact with a former alcoholic. Some of the basic tenets of this successful organization were formulated as a result.

Suggested Reading

Alexander, L.: Treatment of Mental Disorder, Philadelphia, W. B. Saunders Company, 1953, p. 430.

Coleman, J. C.: Abnormal Psychology and Modern Life, 2nd ed., Chicago, Scott, Foresman and Company, 1956, p. 401.

Diagnostic and Statistical Manual Mental Disorders, Washington, D. C., American Psychiatric Association Mental Hospital Services, 1952, p. 14.

Fenichel, O.: The Psychoanalytic Theory of Neurosis, New York, W. W. Norton & Company, Inc., 1945, p. 380.

Fetterman, J. L.: Practical Lessons in Psychiatry, Springfield, Ill., Charles C Thomas, 1949, p. 243.

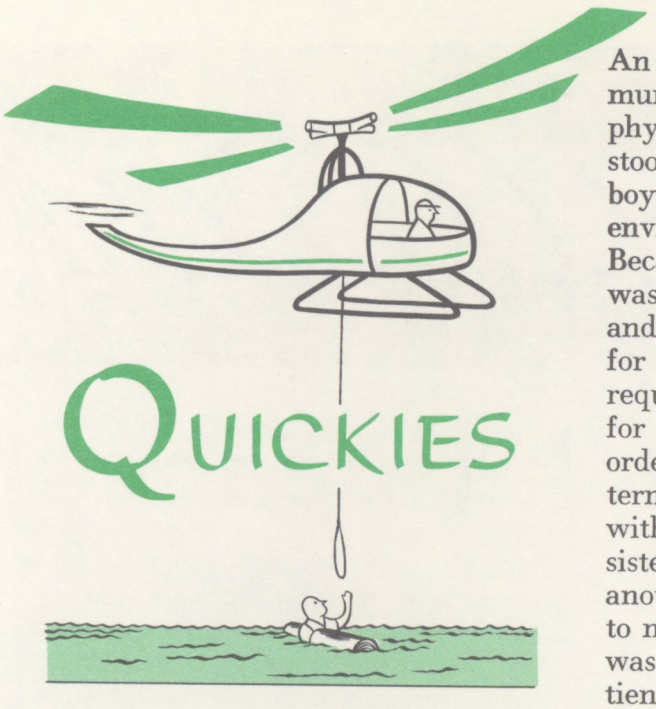
Figurelli, F. A.: Delirium Tremens Reduction of Mortality and Morbidity with Promazine, J. Am. M. A. **166**:747 (Feb. 15) 1958.

Lipton, M. A.: The Recognition and Management of Psychiatric Emergencies, M. Clin. North America **38**:143 (Jan.) 1954.

Muncie, W.: Psychobiology and Psychiatry, 2nd ed., St. Louis, The C. V. Mosby Company, 1948, p. 441.

Romano, J., and Engel, G. L.: Physiologic and Psychologic Considerations of Delirium, M. Clin. North America **28**:629 (May) 1944.

Strecker, E. A., et al.: Practical Clinical Psychiatry, 6th ed., Philadelphia, The Blakiston Company, 1948, p. 154.



ADDICTION IN NEWBORNS: Infants whose mothers are addicted to narcotics may develop typical withdrawal symptoms shortly after birth. The manifestations include irritability, hyperactivity, profuse perspiration, excessive crying and yawning, and, in some cases, vomiting, diarrhea, and convulsions. Onset of symptoms in the newborn often coincides with the mother's withdrawal symptoms. Treatment consists of administration of barbiturates, paregoric, or morphine in gradually decreased doses. Withdrawal symptoms do not occur in all infants delivered of addicts, and, in some instances, symptoms are so mild that no specific treatment is required. If the disorder is severe, however, and its cause is unrecognized, the outlook is likely to be unfavorable. The mortality rate has been cited at as high as 93.2 per cent of untreated cases.

Roman, L. P., and Middelkamp, J. N.: Narcotic Addiction in a Newborn Infant, J. Pediat. **53**:231 (Aug.) 1958.

BRIEF PATIENT CONTACT: An important aspect of physician-patient relationships is that of accurate communication. This is particularly significant when the interaction is limited to a short period of time. The patient may not express his problems clearly, or may select a superficial complaint with the expectation of subsequent opportunity to describe a more troublesome disorder. If this maneuver is not recognized, the physician may alleviate the minor problem and dismiss the patient, with the primary disturbance unresolved. An opposite kind of inadequate communication is that in which the physician's comments are misunderstood. For example, an 18-year-old boy, reared in an excessively strict environment, contracted gonorrhea. Because of fear and guilt, the patient was unable to confide in his parents, and delayed consulting a physician for several months. When he did request treatment, he was berated for the delay and told that the disorder could cause sterility, which term, to the patient, was synonymous with impotence. This conviction persisted for years, until he consulted another physician because he wished to marry and believed that marriage was precluded for him. As the patient had been reared in the belief that severe punishment was an inevitable consequence of transgression, his emotional problem could not be considered iatrogenic; nevertheless, the specific misunderstanding could have been corrected immediately by a more complete explanation.

Betts, C. S., and Reese, W. G.: Understanding Interpersonal Relationships in Brief Contacts with Patients, J. Arkansas M. Soc. **55**:121 (Aug.) 1958.

TOE WALKING: During the process of learning to walk, many children demonstrate a tendency to walk on their toes. Usually, this manifestation disappears with improved muscular coordination, but if it persists, and there is no evidence of neuromuscular or orthopedic disorder, the possibility of psychiatric disturbance should be considered. In conjunction with other signs, toe walking may be indicative of childhood schizophrenia. Case histories were reported in which three children had toe walked consistently until two of them were nine years old, and one was eleven. One child's disorder had been diagnosed as cerebral palsy, another was simply called hyperactive, and the third had had an operative procedure to lengthen the Achilles tendons. All three patients were later diagnosed as schizophrenic. A review of histories of schizophrenic children who were not toe walking has shown either a past history of such activity, or a particular interest in it, as demonstrated by drawings. The suggestion is made that toe walking in schizophrenic children may be related to preoccupation with space and motion, as a result of primary or secondary vestibular dysfunction.

Colbert, E. G., and Koegler, R. R.: Toe Walking in Childhood Schizophrenia, J. Pediat. **53**:219 (Aug.) 1958.

PSYCHOSOMATIC OR PSYCHONEUROTIC: Clarification of the terms *psychosomatic* and *psychoneurotic* has become necessary because of popular misuse in designation of physical symptoms and signs. The distinction in meaning is of more than academic interest, as misapplication may result in inadequate treatment of the patient. Psychosomatic signs and symptoms result from the direct action of emotions, while psychoneurotic ones are the indirect results of symbolic action. Psychosomatic disorders affect the organism by intervention of the autonomic nervous system, and are usually manifested as overactivity of a function. Psychoneurotic signs and symptoms result from the action of the voluntary nervous system when repressed conflicts are resolved symbolically by use of an organ or body-function. Usually, these symptoms are manifested as loss of function.

The evaluation of a patient with nonorganic abdominal pain has been cited as an example. If the disorder is psychosomatic in origin, the patient will probably have a history of anxiety, agitation, insomnia, and other evidence of tension. Palpation of the abdomen consistently produces tenderness and resistance, without involuntary spasm or rebound phenomenon. The reason that the patient appears anxious is that psychosomatic abdominal pain is evidence of failure to manage emotional distress. This is a serious manifestation since it may be a precursor of psychosis or suicide. In contrast, if the disorder is psychoneurotic in origin, the patient's emotional attitude is superficially opposite, and except for the complaint of abdominal pain, the patient will seem to be content, relaxed, even indifferent, or, possibly, flippant. The reason for a different attitude in psychoneurotic abdominal pain is that this form of disorder does alleviate anxiety, provides a kind of relief from emotional conflict, and probably negates the immediate danger of mental disorganization. Obviously, psychiatric treatment would be necessary in both cases, and the first patient's need would be urgent.

Solomon, P.: Psychoneurotic Versus Psychosomatic Abdominal Pain, Am. J. Gastroenterol. **30**:129 (Aug.) 1958.

Parental Influence in

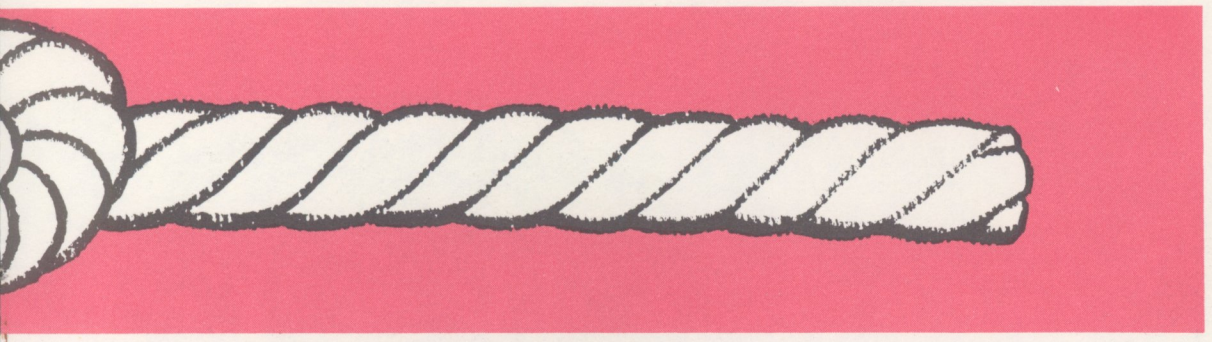
● According to Kanner, ". . . the correlation of childhood schizophrenia with parental attitudes is far higher and more consistent than its correlation with heredity, configuration of the body, metabolic disorders, or any other factor." This opinion is shared by a great many investigators. Those who dispute it remark the occurrence of schizophrenia in children of seemingly adequate parents, and the incidence of one schizophrenic child in a family with other normal children. Until the etiology of schizophrenia has been determined, and, indeed, until it is known whether the disorder is an entity, the necessity for investigation of every aspect is indisputable. Actually, the study of schizophrenic patients has shown a preponderance of adverse parental attitudes which vary from actual psychopathology to subtle, covert destructive influences.

In order to define the significance that parental attitude has in a child's emotional development, the meaning of such influence to the child may be considered first. The child has a fundamental need to feel that his environment is safe and stable, and that he is worthy of a place in it. Because of his prelogical thinking and suggestibility, the child cannot evaluate objectively. Therefore, his concepts of environment and of himself are derived from the attitudes of persons around him, usually his parents. These attitudes are accepted uncritically because, to a child, the parents seem to be omnipotent and omniscient. If the parental attitude is one of rejection, the child develops a self-image of worthlessness. The thought that the all-knowing parent might be at fault is so untenable that the child is forced to accept his own inadequacy. If the parent is overprotective, the effect is somewhat the same because, by implication, the idea is conveyed that the child is incapable of self-management. Kanner said that the rejected child lives in an "emotional refrigerator," the overprotected one, in a "heated oven." Kanner also described parental demand for perfection in the child as a mechanism in which rejection and overprotection are combined. The implication here is that the child is unacceptable as he is, but that he can win approval by certain achievements. A common example is that in which a parent insists that the child memorize and recite long passages or lists of names before the child can read or even know the meaning of the words. Such a practice may be contributory toward the symptom of counting and naming which is characteristic of some schizophrenics. It may also affect the lack of appreciation for conventional semantic values.

Bateson and associates have suggested a theory which is based upon communication analysis and provides that a situation called the *double bind* is inherent in the development of schizophrenia. The double bind consists of conflicting parental directives, which are so constructed that compliance with either will result in the child's being at fault. The directives may be expressed verbally, by attitude, or by a combination of these methods. Whatever the form, they are opposite messages. The double bind is not a single, traumatic experience, but represents, instead, a continued pattern of parent-child interaction. For example, a boy who was recovering from a schizophrenic episode was visited in the hospital by his mother. He greeted her affectionately and put his arm around her shoulder. The mother stiffened and turned away, and the boy withdrew his arm. She then asked him if he did not love her any more. The patient blushed, and the mother chided him for his embarrassment and said that he must learn to express his feelings. After the visit, the patient struck an attendant and required sedation. The result of a child's being subjected to inconsistent attitudes is that he cannot learn to discriminate what exactly is meant by particular forms of communication. If his gestures of affection are met by withdrawal, then he either must conclude that withdrawal is the proper expression of love or that it is not and, therefore, his parent does not love him. Obviously, the child will prefer to accept the first conclusion, and subsequent communication with others will be based upon faulty logic. The schizophrenic is not only unsure about interpretation of what is said to him, he is also unsure of the means to express his own feelings in a way that will be readily understood.

As the child develops in an atmosphere of rejection, overprotection, or perfectionism, he is continually assured, directly or indirectly, of his unworthiness. Because the child still hopes to obtain parental love, he will try various methods of behavior. If one of these seems to be successful, it will become his prevailing pattern of relating to others. Arieti described three common methods and the resultant personality types. By the first, the child discovers that he may gain approval only by compliance with his parents' wishes and denial of his own. This child becomes a submissive person. In the second, the child learns that the parents will yield if he cries or has a temper tantrum. In this case, the child develops an aggressive, hostile personality. Finally, if neither compliance nor aggressiveness is effective, the child simply avoids close parental contact by maintaining emotional distance. As an adult, this person has an aloof, detached personality. These types may, of course, be demonstrated as mixtures.

When none of these methods results in parental approval or in self-esteem, the child feels helpless. Several investigators have cited schizophrenic withdrawal from reality as a method of adjustment to an intolerable parent-child relationship.



SCHIZOPHRENIA

The particular type of parental behavior which results in a destructive relationship is often referred to simply as rejective or overprotective. There have been, however, a number of studies directed specifically toward the details of such parental attitudes. For many years, it was believed that an adverse maternal attitude was the most significant one. In fact, the term *schizophrenogenic* was first used as "schizophrenogenic mother." This theory has not been disproved, and there is considerable evidence in substantiation. More recently, however, there have been reports about adverse paternal attitude. Seemingly, the father's destructive behavior may affect the child in direct father-child interaction, or it may inhibit the mother's efforts toward care of the child. Arieti remarked that the histories of schizophrenics usually show that both parents failed the child.

The following case history, reported by Eisenberg, illustrates the extensive effects of adverse paternal attitude. The father was an eminent surgeon, the youngest of eleven siblings and the most successful in terms of money and prestige. His approach to patients, however, was almost completely mechanical. If possible, he preferred to limit his patient-contact to the actual operative procedure, and he boasted that he never "wasted time" in talking to patients or their families. He was conscientious about details of postoperative care, but delegated the performance to assistants. Because of adherence to a strict schedule in which every aspect of the day was planned to be productive, he was able to accomplish a prodigious amount of work. Time to be spent with his family was not included in the schedule, because he felt no need for it. Relaxation was recognized as necessary, and was provided for by a half-day each week for fishing—alone—and a vacation trip every four months—also alone.

The mother had been an alert, attractive person when they married. Gradually, however, she became oppressed by her husband's forbidding, unaffectionate manner, and, after his repeated contemptuous dismissal of family problems as too petty to trouble him, she became hesitant to ask for his attention even in important matters. When the mother was first interviewed, her manner was subdued, uncertain, and pathetic.

The patient, the third of their children to show emotional disturbance, was a pronouncedly autistic child. In reply to the mother's suggestion of psychiatric consultation, the father had stated that the child would "outgrow this nonsense." Finally, however, he agreed to an appointment.

When the father was interviewed, he arrived exactly on time, and, seemingly, was prepared to deal with the problem in a business-like manner. He began the interview with discreet questions about the psychiatrist's professional qualifications, and, apparently satisfied with them, he reported the boy's symptoms in a detached way. He accepted the diagnosis and its implications without any evidence of personal reaction. It was obvious that the idea of a connection between his attitude and the child's illness was intellectually and emotionally alien to him. The psychiatrist, in an effort to provoke some kind of feeling, asked whether he would recognize the boy if they met on the street. Without any show of resentment, the father deliberated and then replied that he was not sure he would. During discussion of treatment the psychiatrist suggested the possibility of placement in a foster home. The father agreed immediately to this plan, and said that relatives of his would take the child. From the father's viewpoint, the interview was over and the problem had been resolved. Apparently, the idea that either his relatives or the child might have some objection to the plan was not considered.

Fortunately, the outcome was better than had been expected. The mother suddenly demonstrated considerable resourcefulness, and her care and attention to the boy resulted in remarkable improvement on his part. The father, throughout the treatment of the child, remained detached and unconcerned.

It should be remembered that adverse parental attitudes are rarely deliberate. Instead, they are products of the parents' own unfortunate experiences, operant at unconscious levels.

Schizophrenia does also occur, of course, in children of seemingly adequate parents or in one child in a family of normal children. Bender's theory of multiple cause is pertinent to this development. "The parent-child relationship or the emotional climate of the family, especially in the first two years, will help determine the defense mechanisms, the ability to handle regressive tendencies, impulses, anxiety, etc. In other words, no child can develop schizophrenia unless predisposed by heredity; the psychosis is precipitated by a physiological crisis; the pattern of the psychosis and its defense mechanisms are determined by environmental and psychological factors."

Suggested Reading

Arieti, S.: Interpretation of Schizophrenia, New York, Robert Brunner, 1955, p. 43.

Bateson, G., et al.: Toward a Theory of Schizophrenia, Behavioral Science **1**:251 (Oct.) 1956.

Bender, L.: Childhood Schizophrenia, Psychiatric Quart. **27**:663 (Dec.) 1953.

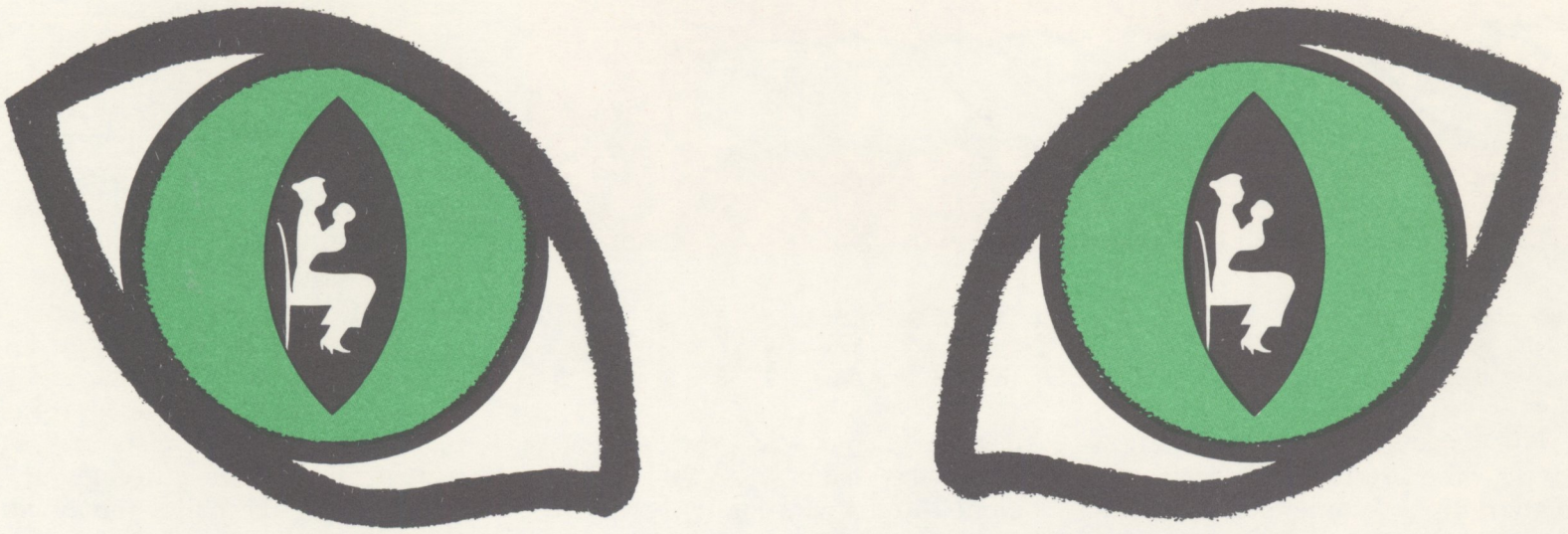
Eisenberg, L.: The Fathers of Autistic Children, Am. J. Orthopsychiat. **27**:715 (Oct.) 1957.

Kanner, L.: Child Psychiatry, 3rd ed., Springfield, Ill., Charles C Thomas, 1957, p. 117.

Lidz, I., et al.: The Role of the Father in the Family Environment of the Schizophrenic Patient, Am. J. Psychiat. **113**:126 (Aug.) 1956.

Prout, C. T., and White, M. A.: Controlled Study of Personality Relationships in Mothers of Schizophrenic Male Patients, Am. J. Psychiat. **107**:251 (Oct.) 1950.

Wahl, C. W.: Some Antecedent Factors in the Family Histories of 392 Schizophrenics, Am. J. Psychiat. **110**:668 (Mar.) 1954.



The Jealous Child

● JEALOUSY is not a simple, single emotional reaction. It is an expression of anxiety, hatred, anger, self-pity, grief, fear, and guilt. In children, as in adults, jealousy is usually a combination of anger, self-pity, and grief. Although jealousy in children is recognized as a normal or even instinctive reaction, parental mismanagement may result in emotional problems which can endure.

Cause and occurrence

According to Anna Freud, the basic cause of jealousy is threatened loss or depletion of the love, attention, and actual physical care upon which a young child depends for survival. Fear of such loss and resentment of divided attention begin as soon as a child recognizes that other persons also receive part of the maternal devotion which he had supposed was exclusively his. The resentment of divided attention is, of course, an integral part of the Oedipal situation, and jealousy of one parent may be demonstrated overtly. An open display of the wish to dispose of a parental rival, however, frequently results in strong feelings of guilt and discomfort. Therefore, the inclination toward such expression is likely to be suppressed, and, instead, hostility is directed toward other rivals.

Jealousy toward a sibling is most common in a first-born child. According to Bakwin and Bakwin, jealousy occurs more frequently between children of the same sex, and the incidence is higher in girls. Resentment of a sibling is most intense if the older child is between the ages of 18 months and three years when the younger child is born. At this period, the child is emotionally dependent upon his parents, is aware of their affection, and does not yet feel secure enough to share it. Isaacs remarked that many children at this age react to the birth of a sibling by feelings that they must have misbehaved or failed to please; otherwise another child would not have been wanted.

Preventive measures

The importance of preparing a child for the birth of a sibling should be emphasized to parents and a thorough explanation made. If the child is less than three years old, his concept of time is unclear, and, therefore, he need not be told of the anticipated birth more than a few weeks in advance. He should, however, be prepared by general discussion, and by specific encouragement toward less dependence and greater self-sufficiency. The child who is older than three years may be told earlier, may help with preparation of the room and selection of infant clothing, and may be taught small tasks which will contribute to the care of the infant. If the birth of a sibling will alter the actual living arrangements of the first child, such changes should be made several weeks beforehand. For example, Kanner cited an instance in which a child had had thorough verbal preparation, and seemed to look forward with pleasure to a brother or sister. The child stayed with his grandparents while his mother was in the hospital. When he came home, he found that his own room had been converted into a nursery, his toys stored away, and his new room was in the attic. The child's reaction was, of course, a violent dislike for the baby.

Several points about preparation have not been sufficiently emphasized in parent guidance writings. One is that even optimal preparation cannot entirely eliminate jealousy. Too often, parents comply meticulously with directions and then are distressed when the older child shows hostility. Baruch suggests that explanation to an older child include discussion of the adverse reactions he may experience. For example, the child should be told that he may feel, at times, that the baby is an unwanted intruder, may wish that the baby had not been born, and that the situation would be more satisfactory without him. If the older child is

made aware that expressions of hostility are not unexpected, he will be less likely to fear loss of parental love by such expressions.

So much has been said about preparation of the older child that some investigators have become concerned about neglect of the younger child. Parents seem to feel that any evidence of jealousy in an older child represents failure on their part, and, consequently, increase their attention to him to the extent that the younger one then feels rejected.

Ordinal position

As children grow older, their ordinal position affects, to some extent, the precipitation of jealousy. The eldest child, of course, may continue to resent the intrusion of the others. Usually, the strongest feelings of jealousy are toward the second child, and, occasionally, the eldest attempts to form a kind of alliance with the youngest against the middle child. The second child may be jealous of both older and younger siblings. To him, the older may seem capable of accomplishments which he can never achieve, with similar parental approval. The younger child may seem better loved because he receives the kind of care no longer needed by the second child. The youngest child may develop resentment of the privileges of older children, may be frustrated by inability to compete with them, and may develop a feeling of futility toward any effort to claim special attention. In families of four or more children, jealousy is less likely to be a problem, partly because of division of maternal attention, and partly because the children themselves form a more self-sustaining unit.

Although sibling rivalry is the most common form of childhood jealousy, the only child is not exempt from such feeling. Every child experiences anxiety about the possibility of another child in his home. When a sibling is born, the dreaded event has actually happened, and the child learns to adapt. By so doing, he also discovers that loss of parental love does not necessarily result. The only child, however, continues to feel anxiety and threat of loss because he is unable to resolve such feelings in actual experience. As a result, he may become possessive toward his parents and overly insistent upon reassurance from them.

Varied manifestations

In addition to overt displays of jealousy, there are several ways in which jealousy is expressed indirectly. Bakwin and Bakwin state that negativism and aggression are the most common. Negativism is, of course, both a form of resistance and a demand for greater attention. Aggression may be expressed directly toward a sibling, the mother, or any other person by such means as biting, pinching, or hitting. More subtle demonstrations include attention-getting devices when the mother is busy with the baby, or reversion to such infantile behavior as thumb-sucking, crawling, and urinary incontinence. In an older child, such indications as nail-biting, sleep disturbance, enuresis, and dietary caprice, as well as selfishness, destructiveness, and restlessness may be symptomatic of jealousy.

Baruch reported a four-year-old boy who was referred to a psychologist because of severe nail-biting, tension, and restlessness. During history-taking, the mother reported that jealousy could not be part of his problem because the boy adored his two-year-old sister. He helped with her care, demonstrated affection toward her, and became upset when she cried. In a play session, the boy was given dolls which represented family figures. He promptly put the sister doll into a toy commode, with the comment that he would drown her.

In addition to the jealousy which is inherent in sibling rivalry, there are several other situations which are also conducive to this reaction. For example, a low socio-economic status may result in envy of the material possessions and social position of other children. Podolsky has remarked, too, that children are acutely aware of the meaning of good health and physical perfection. Any child who is set apart by such illness as diabetes, epilepsy, or rheumatic fever, or a child with a physical deformity is likely to be jealous of well children.

Treatment

The treatment of a jealous child begins with encouragement of emotional expression. Baruch suggests that methods be provided for the child to express anger in a harmless way. For example, modeling clay which can be pummeled is a suitable medium for physical expression. Second, the child's verbal expressions of dislike must be accepted. A young child who states that he wishes his brother were dead does not distinguish between death and absence. When a parent reacts to such a statement with shock, displeasure, and chastisement, the child feels guilty and rejected for something that he cannot control. Self-pity can be ameliorated by setting aside a definite time each day to be spent with the child, without interruption. Also, emphasis upon the privileges and advantages of being an older, middle, or younger child will help to alleviate self-pity. Of primary importance, of course, is the assurance of love and understanding at all times.

If jealousy is exaggerated, and the child is unmanageable because of it, psychiatric referral may be necessary. In such cases, the therapist usually treats both parents and child. The parents are helped to revise their own attitudes. The child is helped to release his feelings by play interviews, drawing pictures, and opportunities to enact his hostility. Removal to another environment is usually done only in instances in which there is actual danger to another child.

A certain amount of jealousy is a normal part of family interaction. If parents can act as moderators without partiality, sibling rivalry provides an excellent opportunity for children to test and measure themselves in a protected atmosphere. The process will help to prepare them for the reality of adult competitive living.

Suggested Reading

Bakwin, H., and Bakwin, R. M.: Clinical Management of Behavior Disorders in Children, Philadelphia, W. B. Saunders Company, 1954, p. 193.

Baruch, D. W.: New Ways in Discipline, New York, McGraw-Hill Book Company, Inc., 1949, p. 119.

Black, I.: Everyday Problems of the Preschool Child, J. Pediat. **41**:233 (Aug.) 1952.

Freud, A.: Psychoanalysis for Teachers and Parents, New York, Emerson Books, Inc., 1947, p. 29.

Isaacs, S.: The Nursery Years, New York, The Vanguard Press, 1936, p. 84.

Kanner, L.: Child Psychiatry, 3rd ed., Springfield, Ill., Charles C Thomas, 1957, p. 603.

Podolsky, E.: The Jealous Child, Arch. Pediat. **71**:54 (Feb.) 1954.

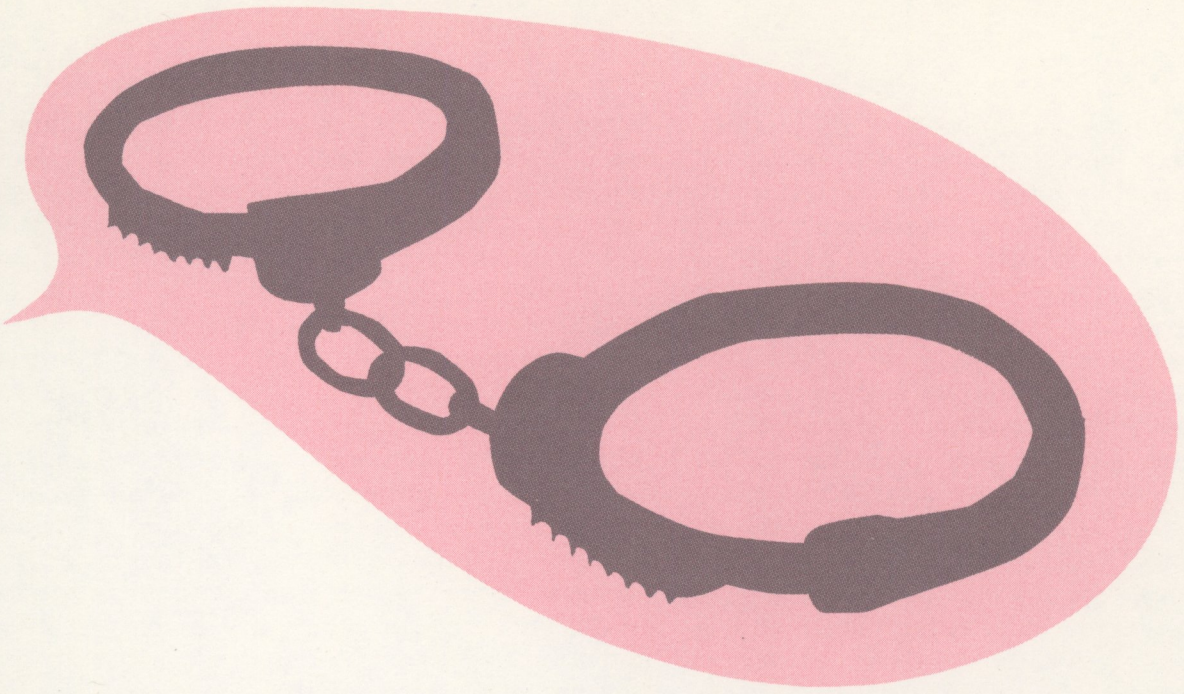
CRIMINAL RESPONSIBILITY

● TWO CLASSES OF INDIVIDUALS are exempt from criminal liability. The first group consists of children under the age of seven, the second, persons of any age who are absolved because of mental disorder. Mental disorder is legally defined as feeble-mindedness or insanity, and, obviously, great difficulty has been encountered in the application of the term insanity. For centuries, legislators have attempted to devise a precise measure to determine the nature and degree of mental illness that would be necessary for exculpation. Psychiatry first became associated with criminology when physicians were asked to assist the courts in evaluation of the mental status of offenders. At first, the issue was simply whether the individual should be held responsible. The many ramifications of such a decision only later became apparent. Primary among these was the matter of management after judgment had been made. An essential purpose of law administration is the protection of society, while that of medical practice is the care of the individual. The combination of disciplines has accentuated the need for some means by which both objectives can be achieved.

The laws of this country were derived from the common law of England, in which persons called natural fools or madmen were considered bereft of reasoning power, and, therefore, inculpable. There was, however, no exact definition of these mental conditions. For example, in 1265, Bracton, chief justiciary of England, defined a madman as ". . . one who . . . is not far removed from brutes." This became known as the *wild beast test*. About 1535, Fitz-Herbert added an amendment in which it was stated that a natural fool was one who could not ". . . account or number 20 pence, nor tell who was his father or mother, nor how old he is." One hundred years later, Sir Matthew Hale introduced an opposite kind of definition by his description of a person who should be considered culpable. His words were ". . . . such a person as labouring under melancholy distempers hath yet ordinarily as great understanding as ordinarily a child of fourteen years hath, is such a person as may be guilty of treason or felony." This became known as the *14-year-old child test*. Soon afterward, the concept of lunar influence upon the diseased brain became popular. It was believed that madmen experienced the height of distemper at the full change of the moon, and were relatively lucid during other phases of lunar activity. In 1671, Hale said that madmen who committed crimes at a time other than the full of the moon must be considered responsible for their acts.

Later, several other concepts were suggested in explanation of criminal behavior. Although not all of these ideas were specifically connected to insanity, they did perpetuate the belief that criminals belonged to a group separate from the rest of society. For example, Franz Gall (1758-1828) introduced the idea of phrenology, in which mental faculties were related to the conformation of the skull. This theory was applied in the spectacular European trial of Tardy, the pirate, whose bumps of combativeness and acquisitiveness were larger than his bump of veneration.

In 1857, Morel stated that criminals and the mentally ill represented a particular form of degeneracy.



Lombroso, in 1876, reported the results of post mortem examination of a vicious criminal. Apparently, the brigand had several rudimentary anomalies of the skull. Lombroso concluded that a criminal was an ". . . atavistic being who reproduces in his person the ferocious instincts of primitive humanity and the inferior animals." At the same time (1877), Dugdale published a genealogy of the Jukes family, which was accepted as proof of the existence of degenerate human stock. The additional theory of hereditary transmission was also well received.

The idea of "moral insanity" had been an underlying feature throughout the 19th century. This concept was developed by Pinel (1806), Prichard (1835), and Ray (1860). These investigators employed the word *moral* in a sense that was different from its present conventional meaning. For them, it denoted affective or emotional derangement. There was a large group which opposed this theory, however, as is attested in the *American Journal of Insanity* for April, 1853. In this publication, it was suggested editorially that caution should be exercised in diagnosis of moral insanity. This controversy culminated in 1882 at the trial of Charles J. Guiteau, who had assassinated President Garfield. The experts who testified in defense emphasized Guiteau's familial history of insanity, personal religious fanaticism, and the degenerative asymmetry of his head and eyes. They asked that he be considered morally insane. The prosecution denied the existence of moral insanity. The jury decided that Guiteau was responsible for his act, and he was sentenced to be hanged. Subsequently, use of the term moral insanity to designate a psychiatric entity was gradually discontinued.

After the idea of moral disease had been discredited, the term *psychopathic inferiority* was introduced by Koch in 1888, and later elaborated by Meyer who, in 1905, added the word *constitutional*. This expression connoted disturbance in persons for whom education and training did not result in socially acceptable behavior. In America, the influence of early emotional stress was emphasized as a causative factor. In 1952, this form of disorder was classified as *antisocial reaction*, under the main heading of *sociopathic personality disturbances*.

The recognition of sociopathic disturbances was, in part, an outgrowth of the search for a suitable legal definition of insanity. Identification of such disorders has, of course, been helpful, particularly since many of the individuals who are brought to the attention of the courts would be so classified. The problem of determination of criminal responsibility, however, remains unsolved, because, legally, sociopathic offenders are answerable for misbehavior, and, psychiatrically, are considered to have some form of character disorder.

Present status of criminal responsibility

In 1958, in Great Britain and in the United States, determination of criminal responsibility is based upon rules established in 1843, formulated after the trial, in England, of a Scot named M'Naghten. M'Naghten had shot and killed Edward Drummond, Sir Robert Peel's secretary. For several years before, M'Naghten had had delusions of persecution, and had decided that he must kill Sir Robert Peel in order to protect himself. Drummond was shot by mistake. According to Diamond this instance was "truly the first trial in which the authority of medical science was directly pitted against ancient legal authority." Nine medical practitioners pronounced the accused to be insane, and M'Naghten was acquitted because of unsound mind, and was committed to a mental institution. This decision was greatly criticized by the public. As a result, the House of Lords devised five questions which were answered by 15 eminent judges. These answers became known as the M'Naghten rules. Briefly, the justices concluded that a defendant should not be considered responsible for a criminal act if he were ". . . labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong." This dictum is also called the *right and wrong test*. From the time the M'Naghten rule was first promulgated, there have been both medical and legal objections to it. For example, Lord Bramwell said that "Nobody is hardly ever really mad enough to be within the definition of madness laid down in the judges' answers." Later, in 1888, Lord Coleridge, Lord Chief Justice of England, stated that ". . . the judicial

decisions on questions of insanity were bound by an old authority which, by the light of modern science, was altogether unsound and wrong." If these objections were considered valid in the 19th century, it is not surprising that physicians have had great difficulty in their attempts to comply with the M'Naghten rule in the 20th century. Particular problems have resulted from interpretation of the phrase "nature and quality of the act", and the words "know" and "wrong." In some court decisions, "nature and quality" have been considered to be synonymous and to mean only the physical nature of the act. In others, the two words have been interpreted to mean different aspects of perception. Difficulty with the word "know" has resulted from whether superficial knowledge, or complete insight into the full significance of the crime and its consequences was meant. Whether "wrong" meant morally wrong or illegal has still not been answered.

In 1929, a supplement was added to the M'Naghten rule in which it was stated that a defendant was not criminally responsible if it could be established that he had been impelled by an irresistible impulse. This became known as the *irresistible impulse test*, inherent in which was the assumption that mental illness causes sudden impulses to break laws.

In 1954, the Durham decision received considerable attention. Monte Durham was convicted of housebreaking. The defense testimony included a statement that the defendant was of unsound mind at the time. The decision was reviewed by the Court of Appeals, and was reversed. In essence, the Durham test provides that ". . . when the criminal act of the accused is the product of his mental illness, the suggested conclusion is that the accused be hospitalized for treatment and possible rehabilitation . . ." Another significant statement was that a psychiatrist should be permitted to give any relevant testimony about the defendant's mental status, instead of being limited to testimony as to the defendant's ability to distinguish right from wrong. The chief objection to the test has come from conflicting interpretations of the word "product."

In general, the M'Naghten rule is considered to be too stringent, the irresistible impulse test, unrealistic, and the Durham test, too vague. From time to time, alternative recommendations have been made. None of these, however, has been satisfactory enough to be adopted.

The American Law Institute has recently appointed a committee to prepare a model code of criminal law. The committee members include judges, lawyers, psychiatrists, sociologists, anthropologists, and criminologists. This group began its task by evaluation of the existing systems, which differ from state to state, and some of which are much superior to others. When the work is completed, the committee hopes to have a pattern for future legislation.

Conclusion

It is obvious that controversy continues to exist in determination of criminal responsibility, perhaps because, to society, exculpation on the grounds of insanity connotes escape from punishment. Even a so-called enlightened society has not rid itself of belief in the ancient *lex talionis*, or "eye for an eye" doctrine. Despite centuries of cumulative evidence of the inefficacy of revenge, a strong impulse toward retaliation in kind persists and underlies the total cultural attitude toward criminality.

Contrary to popular belief, offenders who are adjudged mentally ill actually are confined in institutions for a greater average length of time than are persons who serve prison sentences. Furthermore, in many states, when a mentally ill offender has regained sufficient reasoning power to understand that he committed a crime while ill, he must then make retribution for his act. This policy often results in doubled and tripled length of confinement because, in many states, time spent in a mental hospital cannot be credited to a sentence nor applied toward parole eligibility. For example, an individual whose crime required ten years' imprisonment might spend five years in a mental hospital, and then, when the hospital authorities considered him well enough to return to the community, he would be sent to prison for the original ten years.

Finally, the most adverse situation, both for the individual and for society, is that in which a mentally ill offender is simply sent to prison. The present penitentiary system originated in the latter part of the 18th century. It was adapted from the religious practice of monastic solitude, and it was intended to promote reform by the salutary effect of meditation. Although extensive improvements have been made in many prisons, the programs for rehabilitation, education, and entertainment of prisoners are planned primarily for inmates who are not mentally ill. Furthermore, for most prisoners, the greater portion of time is spent in cells. The mentally ill offender who is sent into such a situation may meditate indefinitely in a cell without alteration in his emotional disorder. In most cases, this offender will serve the required number of years, and will be released to the community with exactly the same attitude he had when his crime was committed. By this method, the individual is not helped, and society is protected only temporarily.

Until the currently inadequate psychiatric services in prisons can be expanded, it would seem advisable to be less concerned about whether a mentally ill person might escape punishment and more concerned about correction of his illness. Such correction would be aided by a medically workable statute for determination of criminal responsibility.

Suggested Reading

Board, R. G.: An Operational Conception of Criminal Responsibility, Am. J. Psychiat. **113**:332 (Oct.) 1956.

Board, R. G.: Reply to Dr. Friedman, Am. J. Psychiat. **114**:424 (Nov.) 1957.

Bromberg, W.: Crime and the Mind, Philadelphia, J. B. Lippincott Co., 1948.

Diamond, B. L.: Isaac Ray and the Trial of Daniel M'Naghten, Am. J. Psychiat. **112**:651 (Feb.) 1956.

Friedman, L.: Correction and Retribution in the Criminal Law, Am. J. Psychiat. **114**:421 (Nov.) 1957.

Guttmacher, M.: The Quest for a Test of Criminal Responsibility, Am. J. Psychiat. **111**:428 (Dec.) 1954.

Henderson, D., and Gillespie, R. D.: A Text-Book of Psychiatry, 8th ed., London, Oxford University Press, 1956, p. 706.

Nice, R. W. (ed.): Crime and Insanity, New York, Philosophical Library, Inc., 1958.

O'Reilly, J. J.: Criminal Responsibility, Birmingham M. Rev. **28**:234 (Summer) 1954.

Willie, W. S.: Psychiatric Facilities in Prisons and Correctional Institutions in the United States, Am. J. Psychiat. **114**:481 (Dec.) 1957.

Young, K.: Personality and Problems of Adjustment, 2nd ed., New York, Appleton-Century-Crofts, Inc., 1952, p. 638.

Ernest Jones

Ernest Jones was born in Wales, at Gowerton, Glamorgan, on January 1, 1879. He was the son of a mining engineer, and attached particular importance to his Welsh origin because he believed that the outlook of the Welsh had been influenced by centuries of defeat and suffering.

Jones began the study of medicine at University College, Cardiff, and continued his clinical training at University College Hospital in London. In 1901, he obtained the degree of Bachelor of Medicine at London University, and, in 1903, the Doctor of Medicine degree. He was especially interested in neurology, and, during a period of postgraduate study in Munich, learned the German language in order to read the copious reports of German neurologists and psychiatrists. In 1905, Jones read Freud's short account of the analysis of a young woman's hysterical symptoms. Later in the same year, Jones undertook the psychoanalysis of the wife of an American neurologist. This was the first time the procedure had been attempted outside the German-speaking countries. Within the next two years, he met Jung and planned with him for the first International Congress of Psychoanalysis which was held at Salzburg in 1908. There Jones heard Freud speak, and promptly became a proponent of that particular school of psychotherapy.

In 1909, Jones was appointed head of a new psychiatric clinic in Toronto. He was a founder of the International Psychoanalytic Association in 1910, and of the American Psychoanalytic Association in 1911. Despite tireless effort to promote the concepts of psychoanalysis, Jones' work was not entirely well-received in North America, and, in 1911, he decided to return to England, although he commented that in England, also, there was "a cold antipathy" to the whole subject.

He remained in England as director of the London Clinic for Psychoanalysis, and maintained an active private practice. He also taught, lectured, and organized meetings to introduce psychoanalysis and to further its acceptance. In 1913, he established the British Psychoanalytic Association, of which he was president until 1944. In 1920, he founded the *International Journal of Psychoanalysis* of which he was editor from 1920 to 1939. He was elected Fellow of the Royal College of Physicians in 1942, and remained Honorary President of the International Psychoanalytic Association until his death. Jones received two honors which pleased him especially. One was the winning of favorable comment from a committee of the British Medical Association in 1929. He called this ". . . my most difficult achievement on behalf of psychoanalysis." The other came in 1954 when he was awarded the honorary degree of Doctor of Science from the University of Wales.

Jones wrote extensively about a variety of subjects. In addition to theoretical expositions and case reports, he applied psychoanalytic concepts to anthropology, literature, religion, politics, and even to chess-playing. Some of the most notable of these applications were in his writings on *Hamlet*, which have received recognition by many Shakespearean scholars. He also became a leading figure skater, although he did not begin this activity until the age of 40. In 1931, he wrote a manual entitled *The Elements of Figure Skating*, an edition of which was still being requested as late as 1952.

For many years, Jones' *Papers on Psychoanalysis* was second only to Freud's *Introductory Lectures* as a textbook of the subject. Particularly lucid contributions were made by Jones in his erudite essays on dreams, symbolism, and character formation, as well as the discussions of suggestion, anxiety, hostility, jealousy, and other clinical aspects of psychoanalysis. His explanation of anal-eroticism is considered to be the definitive work on this subject. Shortly before his death, Jones completed a three-volume biography entitled *The Life and Work of Sigmund Freud*, which has been acclaimed as a classic. Jones' loyalty and devotion to Freud were dramatically demonstrated during the Nazi occupation of Vienna, when Jones succeeded in removing Freud, who was then 82 years old, and his family to London, away from the danger and inevitable humiliation to which they were exposed.

Jones died on February 11, 1958 at University College Hospital. His wife, Katherine, and two sons and a daughter survive him.

Suggested Reading

Ernest Jones, Lancet **1**:438 (Feb. 22) 1958.

Ernest Jones, M.D., D.Sc., F.R.C.P., Brit. M. J. **1**:463 (Feb. 22) 1958.

Ernest Jones, Psychoanalyt. Quart. **27**:157 (April) 1958.

Glover, E.: On the Early Development of Mind, New York, International Universities Press, Inc., 1956, p. 52.

Jones, E.: The Death of Hamlet's Father, in Phillips, W. (ed.): Art and Psychoanalysis, New York, Criterion Books, Inc., 1957, p. 146.

Jones, E.: The Life and Work of Sigmund Freud, New York, Basic Books, Inc., 1957.

Encephalitis

● During the early part of the 19th century, references to a disease variously called brain fever, hydrocephalic fever, or "sleeping sickness" began to appear in medical journals. Pinel may have been the first to describe brain fever. At least, he is credited with differentiation of the disorder from meningitis. After 1850, the disease seemingly disappeared for a time. Later, in 1915, several cases of an infectious disease of the brain were reported in Roumania, and, in 1917, Constantin von Economo identified more cases in Vienna as *lethargic encephalitis*. By 1919, the disease had spread to America where it caused an epidemic. Because lethargy was not always present, the name was changed to *epidemic encephalitis*.

Diagnostic characteristics

Although it is necessary to distinguish types of encephalitis for etiologic, nosologic, and epidemiologic purposes, Wechsler has suggested that, clinically, encephalitis may be considered a generic term. In his words, ". . . paradoxically, it is the varied clinical manifestations which alone appear to lend some unity. It is not so much the obscure etiologic factors, nor the ill-determined pathologic process, as the anatomical localization which determines in the main the clinical picture." The manifestations that are characteristic of most cases of encephalitis include a usually acute onset, mild fever, pupillary and ocular disturbance, disorders of motility, which may be hyperkinesis, hypokinesis, or paralysis, and mental symptoms which vary from irritability to coma. The most significant feature of encephalitis is the evidence of disseminated disease. In almost all cases there are multiple foci of involvement with pathologic affection of widely separated parts of the nervous system. Finally, if diagnosis has not been made in the acute phase, the sequelae are typical enough to establish the fact that the patient had encephalitis.

Encephalitis is of particular interest from the psychiatric viewpoint for several reasons. In the acute stages, neurological signs may be minimal, while symptoms of mental disturbance are pronounced. Therefore, immediate differential diagnosis is sometimes problematic. In the chronic phase, the postencephalitic symptoms may be evidenced as extraordinary behavior changes for which the patient requires psychiatric care and, possibly, confinement in a mental institution. The unusual effect of the disease upon subsequent conduct has resulted in a social problem, as well as a medicolegal one. In recognition of this, a special law was promulgated in England in 1927 which provides that an individual may be certified as mentally deficient even though the defect occurred as late as 18 years of age. The statute was devised for the express purpose of including adolescents who have chronic encephalitis.

Acute phase

In the acute stage, symptoms of delirium, stupor, and psychomotor excitement have all been observed. An exceptional feature of encephalitic stupor is that the patient can be aroused for short intervals and will respond coherently to questions. Another unusual symptom, manifested most often by young persons, is "pressure of talk." The patient talks unceasingly, without alteration in mood, and with complete orientation to environment. Although this symptom is usually limited to the acute, febrile period, one case was reported in which it persisted for three years. Complaints of sleep disturbance are common, with insomnia predominant. It is not rare for two or three nights of complete insomnia to precede other signs of encephalitis. Headache, of course, is one of the most frequent symptoms. Actually, signs and symptoms of encephalitis are so varied in onset that diagnosis may have to be made from the manifestations of later stages. There is a wide age-margin for incidence, the highest having been cited as between the ages of 15 and 50. There have also been patients as young as three months and as old as 87 years.

Lindsay has stressed the need to distinguish acute encephalitic disturbance from functional psychiatric illness. If the symptoms are severe, differentiation from such psychoses as schizophrenic reaction may be necessary. In less disturbed patients, the manifestations may simulate neuroses. The particular importance of differentiation is apparent because of the differences in treatment and prognosis. For example, electric shock therapy might be administered to a patient with schizophrenic reaction, while this form of treatment would be contraindicated for a patient with encephalitis. If patients with mild symptoms are not recognized as encephalitic, they may be treated only by psychotherapy without other attentions necessary to ameliorate toxicity. The problem of differentiation is illustrated in the following case history. A 17-year-old boy, employed as a carpenter's apprentice, developed symptoms of upper respiratory infection on January 16th. He worked the next day and went skating that evening, but came home early with the complaint that his "head was going too fast." He had an elevated temperature for which he was given aspirin. The patient slept throughout the following day, and, in the evening, described the loss of a blue suit, although he did not own one, and stated that he had won several thousand dollars in a race that day. His mental status became progressively disorganized, and he was admitted to a general hospital on January 18th. At that time, he was extremely negativistic, made silly remarks, and sang in a loud voice. Physical examination showed dilation of the left pupil, normal temperature, white blood cell count of 6,400, and spinal fluid cell count of twelve cells per cubic millimeter. By January 21st, the patient was disoriented as to time and place, and a diagnosis of schizophrenic reaction, catatonic type, was made. He was transferred to a psychiatric hospital where his attitude was noted as listless and somnolent. On January 30th, electroencephalographic tracings showed left frontal and temporal asymmetry. On February 1st the

patient began to improve, and was discharged as recovered on February 10th, although pupil irregularity was still present. Evaluation of February 15th showed resolution of all previously abnormal findings. The diagnosis of encephalitis was based on the history of fever, dilated left pupil, and spinal fluid cell count, in conjunction with the disordered mental status. The patient has been well for two years since this illness.

Chronic phase

In the chronic phase, there is considerable difference between children's symptoms and those of adults. Behavior of an adult postencephalitic is usually consonant with his affective state. For example, an apathetic individual will remain motionless for hours and simply stare into space, expressionless although not from preoccupation. In extreme instances, such apathy may result in a totally vegetative existence. Slowed activity may also be associated with postencephalitic Parkinsonism, which is a frequent sequela of the disease. Although there are no specific emotional reactions that are peculiar to postencephalitic adults, such disorders as irritability, bitterness, and depression may result from recognition of chronic infirmity. In contrast to apathy, sustained euphoria has been reported in some patients. The reason for this reaction is not known, though some investigators have suggested a toxic effect. Actual intellectual impairment is rare in adults, although apathy may give the impression of such impoverishment. Sleep disturbance may occur as insomnia, hypersomnia, or an inverted rhythm. Hypnotics are not particularly helpful, and, seemingly, lack of sleep is not as bothersome as it is to normally active persons. Occasionally, such reactions as delusions, hallucinations, or hypochondriasis occur but they are neither common nor specifically related to encephalitis.

In contrast to the usual adult chronic symptoms, behavior disturbances in postencephalitic children are of a restless and aggressive nature. The behavior pattern in children may be called characteristic because there is no other physical disease which causes such after-effects in as large a proportion of cases. For example, in a previously normal, emotionally-balanced child the behavior change after encephalitis may be manifested by irritability, tempertantrums, destructiveness, violence, public defecation and micturition, excessive cruelty to other children and to animals, and precocious sexual activity. Systems of punishment and reward are totally ineffective. In some cases, there is apparently no sense of responsibility, regret, or shame for the actions. In other instances, the children seemingly experience compunction after an unfortunate performance, but the reaction is seldom more than transitory, and, within minutes, misbehavior is resumed. Rarely, the converse of this syndrome occurs, in which an unruly child has become docile after encephalitis.

Another common result in children is secondary intellectual deficiency, which probably indicates lack of concentration. Actual arrest of intellectual development may occur, as it may in any prolonged childhood illness, but after encephalitis, the arrest may be permanent. Sleep disturbances in children are almost always of the inverted rhythm type. Postencephalitic tics occur more often in children than in adults, and are usually more complex movements than those of functional origin.

The prognosis for children with postencephalitic behavior disorders varies individually. Sometimes Parkinsonism develops, with concurrent recession of misbehavior. In other cases, there is progressive improvement but some form of instability usually persists. Children who are less than twelve years of age at the onset of encephalitis are more likely to show improvement.

In adults, the prognosis is equally variable, and it is almost impossible to predict individual outcome. In the acute stage, death has been estimated to occur in from ten to 50 per cent of cases. The course of the chronic stage is highly changeable. Even in the same patient, apathy may be predominant at one time, and euphoria at another. Particular symptoms such as sleep disturbance are subject to remission and exacerbation.

There are no specific treatments for encephalitic patients. Medical treatment is largely symptomatic, while psychiatric care is of the supportive type. The value of sympathy and understanding should not be underestimated, however. Many encephalitic patients have responded favorably in an atmosphere of kindly and individualized attention.

Epidemic Encephalitis: International Incidence

Although epidemic encephalitis is now pandemic, the designations of different types are retained according to the places where epidemics occurred. The types are listed as Vienna type, or Type A; Japanese type, or Type B; St. Louis type, or Type C; Australian X; Russian tick-borne; and Equine, which is subdivided into the Eastern, Western, and Venezuelan types. Each of these types is believed to be caused by a virus of the genus Erro.

Suggested Reading

Casamajor, L.: Brain Fever, J. Am. M. A. **149**:1443 (Aug. 16) 1952.

Henderson, D., and Gillespie, R. D.: A Text-Book of Psychiatry, 8th ed., London, Oxford University Press, 1956, p. 494.

Lindsay, D. S.: Encephalitis as a Psychiatric Problem, Am. J. Psychiat. **107**:131 (Aug.) 1950.

Mulder, D. W.: Western Equine Encephalitis, Dis. Nerv. System **12**:259 (Sept.) 1951.

Noyes, A. P., and Kolb, L. C.: Modern Clinical Psychiatry, 5th ed., Philadelphia, W. B. Saunders Company, 1958, p. 174.

Scott, T. F. McN.: Encephalitis Associated with the Exanthems, Mumps and Vaccination Procedures, M. Clin. North America **36**:1627 (Nov.) 1952.

Wechsler, I. S.: A Textbook of Clinical Neurology, 8th ed., Philadelphia, W. B. Saunders Company, 1958, p. 383.

Book Reviews

A Textbook of Clinical Neurology, *8th edition. By Israel S. Wechsler, M.D. Pp. 782. Price $11. Philadelphia, W. B. Saunders Company, 1958.*

In 1927 the first edition of this important and valuable text was published. More than 30 years later the new version of this volume is even more welcome and needed. A Textbook of Clinical Neurology is exactly what its title says, is indexed in detail, is generously documented, and contains 179 illustrations. For the eighth edition part of the material has been re-edited, part rewritten, and the reference lists have been augmented since the last edition. The chapter on history has not been changed, but the material remains an important condensation of an impressive roster of contributors to the development of a science.

Naven, *2nd edition. By G. Bateson, M.A. Pp. 312. Price $6. Stanford, California, Stanford University Press, 1958.*

The first edition of this contribution to anthropology and social science appeared in 1936, and for the new volume the author has added an epilogue. Naven describes a ritual practice performed in New Guinea by the Iatmul, a tribe of head-hunters. The ceremony is congratulatory in intent, and Bateson has used this particular manifestation as a basis for research into the whole culture. The psychological portent of the ritual in relation to social standards, behavior patterns, and cultural significance is elucidated in this field study. Naven is illustrated with photographs and a glossary is provided.

Basic Facts About Mental Illness. *By H. Milt. Pp. 31. Price $0.50. New York, Science and Health Publications, 1957.*

The author of this pamphlet is the Director of Public Information of the National Association for Mental Health. His purpose is to describe briefly and in lay terminology the most common mental disorders and the therapeutic means available for them. With this intent the author has explained many terms, defined some of the larger categories, and has classified treatment methods into three large groups. The booklet has a foreword by G. S. Stevenson, M.D., who is Medical Consultant for the National Association for Mental Health. This publication can be ordered from Mental Health Materials Center, Inc., 1790 Broadway, New York 19, New York. There is a price reduction for bulk orders.

Chronic Schizophrenia. *By T. Freeman, M.D., D.P.M., J. L. Cameron, Ch.B., D.P.M., and A. McGhie, M.A. Pp. 158. Price $4. New York, International Universities Press, Inc., 1958.*

A psychoanalyst, a clinical psychiatrist, and a clinical psychologist collaborated on this study, made at the Glasgow Royal Mental Hospital. The nursing care, therapy, and possible rehabilitation of the hospitalized patient with chronic schizophrenia were the subjects reviewed, and two groups of the chronically ill were selected for observation. The first group were patients with severe personality deterioration. The second were those with fixed paranoid delusions who yet had some degree of personality integration. This monograph describes three methods utilized for the study, gives selected case histories, and also affords a historical background of theories of the psychopathology of schizophrenia. The preface to the volume is by Anna Freud, the foreword by T. F. Roger.

Orthopsychiatry and the School. *Edited by M. Krugman, Ph.D. Pp. 265. Price $4. New York, the American Orthopsychiatric Association, 1958.*

The 26 papers in this collection pertain to the school as a significant influence on the mental health of children. The 36 contributors have reported study projects on problems of adolescence, on teacher education, on learning problems and on both normal and emotionally disturbed children in the school years. Few bibliographic references are used. Each paper is preceded by a short statement of the thesis, purpose, or circumstances of the project.

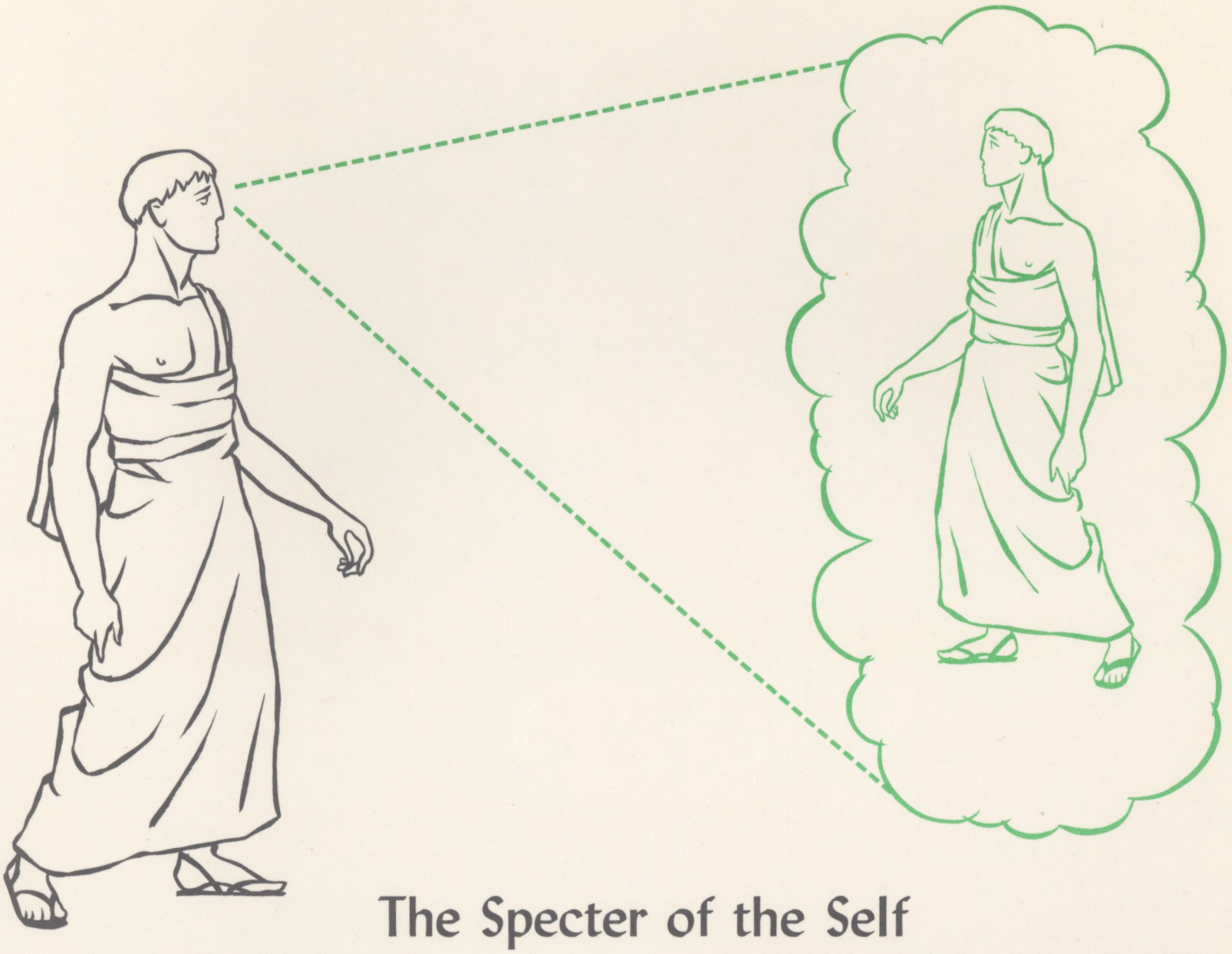
Psychosomatic Ophthalmology. *By T. F. Schlaegel, Jr., M.D., with Millard Hoyt, M.D., as collaborator. Pp. 523. Price $11. Baltimore, The Williams & Wilkins Company, 1957.*

An appraisal of functional and structural disorders of the eye is presented in this monograph by an author who is both ophthalmologist and psychiatrist. The psychological and physiological factors that are operant in disease development are recounted in relation to ophthalmic dysfunctions, and symptomatology, diagnosis, and therapy are all discussed. The largest section of the volume is designated "Ocular Conditions According to Anatomic Location" and includes nine chapters. This section describes the pathophysiology of disturbances of function and structure, according to the part of the eye. Trauma, headache, and allergic disorders are considered in other parts of the volume. There is a brief section on the subject of blindness, and a scrupulously simple account of psychotherapeutic procedures. There is a combined name and subject index, and references are cited at the ends of the chapters.

BOOKS RECEIVED

Analyzing Psychotherapy. *By S. Katzenelbogen, M.D. Pp. 126. Price $3. New York, Philosophical Library, Inc., 1958.*

L'Elettroencefalogramma del Bambino Normale. *By A. Fois. Pp. 140. 101 illustrations. Price 2000 lire. Pisa, Italy, Omnia Medica, Istituto di Ricerche, Via S. Michele degli Scalzi N. 59.*

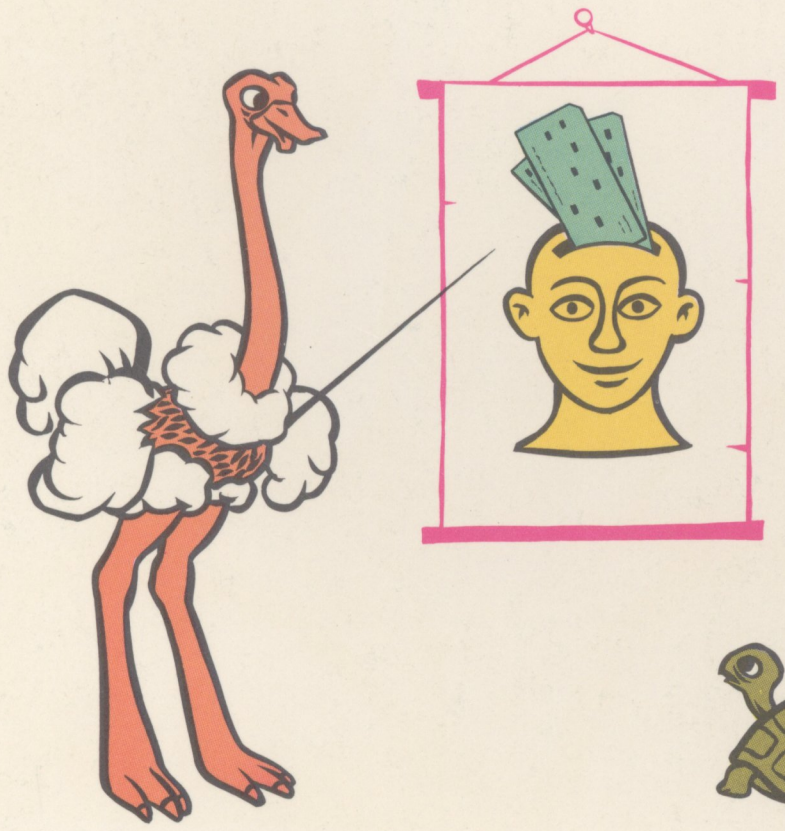


The Specter of the Self

Aristotle described a man who could not go for a walk without seeing his own image come toward him. Schilder called such an experience "autoscopic." In the 20th century, the phenomenon of a spectral self-duplication visible to the patient has been defined as "delusional dislocation of body-image," "hallucinations of physical duality," or "a complex psychosensorial hallucinatory perception of one's own body image projected into the external visual space." The last definition includes the multiple sensations of visual, auditory, kinesthetic, intellectual, and emotional perception. Usually, the double is perceived clearly and in detail as a life-sized, mobile reproduction. Sometimes, although rarely, the specter is seen in color. The most common reactions include sadness, bewilderment, satisfaction, or, in schizophrenic individuals, indifference. There are two main theories of causation. Some believe the disorder results from organic irritation in the temporal, parietal, or occipital areas, others that it is a psychologically induced projection of pictorial memories. Narcissistic preoccupation is probably inherent in either case. There seems to be some relationship to migraine and epilepsy, but no apparent causal connection to psychosis, although the disorder occurs in emotionally disturbed patients, as well as in seemingly normal persons. The normal individual, however, maintains an objective insight into the unreality of the experience.

Lukianowicz, N.: Autoscopic Phenomena, Arch. Neurol. & Psychiat. **80**:199, 1958.

From MEDICAL ARTS PUBLISHING FOUNDATION
Houston 4, Texas



"What we call a mind is nothing but a heap or collection of different perceptions, united together by certain relations, and supposed, though falsely, to be endowed with a perfect simplicity and identity."

David Hume, 1739